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# EUPHEMISTIC CODES AND TELL-TALE HEARTS: HUMANE ASSISTANCE IN END-OF-LIFE CASES

*George P. Smith, II<sup>†</sup>*

*Presently I heard a slight groan and I knew it was the groan of mortal terror . . . No doubt I now grew very pale; but I talked more fluently, and with a heightened voice. Yet, the sound increased – and what could I do? It was a low, dull, quick sound – much such a sound as a watch makes when enveloped in cotton. I gasped for breath . . . but the noise steadily increased . . . Oh God! What could I do . . . They heard! – they suspected! – they knew! . . . I felt that I must scream or die! . . . I shrieked . . . it is the beating of his hideous heart!<sup>1</sup>*

## INTRODUCTION AND HISTORICAL OVERVIEW

A EUPHEMISM IS DEFINED as “the substitution of an agreeable or inoffensive word or expression for one that is harsh, indelicate, or otherwise unpleasant or taboo: allusion to an offensive thing by an inoffensive expression.”<sup>2</sup> This article discusses medical euphemisms used commonly through medical codes in hospitals for end-of-life patient care. It examines the extent to which fear shapes decision-making in critical care units – fear of medical failure, and fear of litigation if not “everything” is done to prolong life, no matter how agonizing. Furthermore, being trained to save lives, health care providers often lack the courage to let a

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<sup>1</sup> EDGAR ALLAN POE, *The Tell-Tale Heart*, in 3 COLLECTED WORKS OF EDGAR ALLAN POE: TALES AND SKETCHES 1843-49, 789, 794, 797, (Thomas Olive Mabbott ed. 1978).

<sup>2</sup> WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE UNABRIDGED 784 (Philip Babcock Gove ed. 1986).

patient die – especially when care has been provided for an extended period of time.

The average drowning person, when asked if he would like a life preserver would usually answer in the affirmative. If, however, such a person were to be told that after receiving the preserver the boat would be unable to land for some two weeks during which time he would be dragged and probably drown he would probably rethink the initial decision to accept the life preserver. Similarly, when requests are made of physicians to “do everything” in critical care settings, many, lacking courage or fearing professional and legal consequences, will not explain the potential results of the procedures to the patient or the family. If, however, candor and honesty were shown in the initial instance, a Do Not Resuscitate Order (DNR) would, more often than not, be written and agreed to by all concerned parties.<sup>3</sup>

Shortly after the development and refinement of resuscitative techniques in the early 1960's, it became clear that only a minority of patients who were successfully resuscitated survived until hospital discharge.<sup>4</sup> Because many resuscitated patients were critically ill, extremely elderly, or severely and irreversibly demented, resuscitation oftentimes served only to prolong suffering or to sustain patients in a persistent vegetative state.<sup>5</sup> Accordingly, physicians, patients and patients' families became increasingly concerned that resuscitation was not always in the best interests of the patient.<sup>6</sup>

Soon, a growing number of physicians shared the opinion that resuscitation of all patients often violated the “ethical principle of non-maleficence (not doing harm),” and because patients and their families or surrogates were increasingly demanding more in-

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<sup>3</sup> See Anita Pursino, *Letter to the Editor*, 20 HEART & LUNG: J. CRITICAL CARE 316, 317 (1991) (highlighting the benefits of discussing resuscitation with patients and families). See generally, Daniel P. Sulmasy et al., *The Quality of Mercy: Caring for Patients with 'Do Not Resuscitate' Orders*, 267 JAMA 682 (1992) (examining the quality of care for patients with DNR orders); Robert M. Walker, *DNR in the OR: Resuscitation as an Operative Risk*, 266 JAMA 2407, 2411 (1991) (advocating appropriate use of intraoperative DNR orders through open and supportive patient-physician relationships).

<sup>4</sup> See Mark H. Ebell, *Practical Guidelines for Do-Not-Resuscitate Orders*, 50 AM. FAM. PHYSICIAN 1293, 1293 (1994) (citing W. B. Kouwenhoven et al., *Closed-Chest Cardiac Massage*, 173 JAMA 1064, 1064-67 (1960)).

<sup>5</sup> See George P. Smith, II, *Utility and the Principle of Medical Futility: Safeguarding Autonomy and the Prohibition Against Cruel and Unusual Treatment*, 12 J. CONTEMP. HEALTH L. & POL'Y 1, 34 (1995).

<sup>6</sup> See Ebell, *supra* note 4.

volvement in the decision to resuscitate, the medical community ultimately developed DNR orders.<sup>7</sup> DNR orders direct hospital staff not to apply resuscitative measures if and when cardiac or respiratory arrest occurs.<sup>8</sup> While it has been well established that physicians acting in concert with competent patients or their designated surrogate decision-makers have the legal right to issue DNR orders,<sup>9</sup> the law provides few clear standards which address them.<sup>10</sup>

There are but two basic responses to individuals in cardiopulmonary arrest: order-code or no code.<sup>11</sup> To code a patient means – in essence – to commence cardiopulmonary resuscitation (CPR). A no code – most commonly, DNR – means no aggressive assistance will be given to a patient in medical distress.<sup>12</sup> Many consider a CPR order to be a “bad prognostic sign” because, put simply, few code survivors leave the hospital.<sup>13</sup> Indeed, an in-hospital survival rate of fifty percent is considered quite impressive.<sup>14</sup>

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<sup>7</sup> *Id.* at 1293-94.

<sup>8</sup> See PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 250-51 (1983) (discussing applicability of DNR orders); Bridget Ann Berry, *The Right to Die: Florida Breaks Through the Legal Deadlock*, 12 FLA. ST. U. L. REV. 607, 620 (1984) (citing *Custody of a Minor*, 385 Mass. 697, 698 n.1 (1982)).

<sup>9</sup> See Carol Ann Mooney, *Deciding Not to Resuscitate Hospital Patients: Medical & Legal Perspectives*, 1986 U. ILL. L. REV. 1025, 1038-44 (1986) (suggesting a framework for determining the appropriateness of resuscitation efforts for hospital patients as well as who should have the legal right to make such decisions).

<sup>10</sup> See *id.* at 1031.

<sup>11</sup> See Judith M. Saunders & Sharon M. Valente, *Code/No Code? The Question That Won’t Go Away*, NURSING, Mar. 1986, at 60, 62.

<sup>12</sup> *Id.* See generally Dean M. Hashimoto, *A Structural Analysis of the Physician-Patient Relationship in No-Code Decisionmaking*, 93 YALE L.J. 362 (1983) (proposing that the prolongation of life should remain a choice for the terminally ill and that no-code status should be an option for a competent non-terminal patient).

<sup>13</sup> J. Gary Grant, *The No-Code Decision—A Doctor’s Perspective*, NURSING, Mar. 1986, at 63.

<sup>14</sup> *Id.* The Council on Ethical and Judicial Affairs of the American Medical Association has reported that in approximately one third of some two million patient deaths occurring in hospitals in the United States each year, CPR is attempted in approximately one-third of this population. Of those receiving CPR, one-third survives and another third of these individuals survive, in turn, until discharge from the hospital. Ultimately, the success or failure of CPR resuscitation depends upon the nature and severity of a patient’s major illness before arresting. See COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, *Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders*, 265 JAMA 1868, 1868-69 (1991) (discussing guidelines for the use of CPR in the absence of DNR orders).

Even for no code patients, frequent re-assessments, perhaps every seventy-two hours, should be made in an effort to re-evaluate a physician's orders and give supportive or palliative care to the distressed patients.<sup>15</sup> Communication of this no code should, as well, be given to all members of the patient's health management team.<sup>16</sup>

CPR was developed originally to preserve life, restore health, relieve suffering, and limit disability of persons who unexpectedly went into cardiac arrest.<sup>17</sup> It is a desperate invasive procedure that was not intended to delay the impending death of patients who are suffering from terminal illnesses. Despite this, health-care institutions have classified CPR as an "emergency" procedure for which patients' consent is presumed absent a pre-directive to the contrary.<sup>18</sup> This classification led to the expanded use of CPR, well beyond the select group of patients for which it was intended, and therefore a pervasive, indiscriminate, and often contraindicated use of CPR by health-care workers.<sup>19</sup> In fact, some states enacted legislation codifying the expectation of resuscitation in an attempt to ensure the administration of CPR to hospital inpatients.<sup>20</sup>

A further cause of the contraindicated use of CPR has been the rise in patient autonomy and informed consent. This rise precipitated the shift in the decision-making power regarding the withdrawal or refusal of advanced life-saving medical technology.

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<sup>15</sup> See Saunders & Valente, *supra* note 11, at 64. See also Roberto Bernabel *et al.*, *Management of Pain in Elderly Patients with Cancer*, 279 JAMA 1877 (1998) (discussing the need to improve proper pain management). See generally George P. Smith, II, *Death Be Not Proud: Medical, Ethical and Legal Dilemmas in Resource Allocation*, 3 J. CONTEMP. HEALTH & POL'Y 47 (1987) (discussing various care issues with respect to end-of-life patients).

<sup>16</sup> See Saunders & Valente, *supra* note 11, at 64.

<sup>17</sup> See Kathleen M. Boozang, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 ARIZ. L. REV. 23, 24 (1993) (citations omitted) (specifying that CPR was originally developed to prevent sudden unexpected death).

<sup>18</sup> See *id.* at 25 (citations omitted). One state, New York, has codified a presumption in favor of resuscitation: "Every person admitted to a hospital shall be presumed to consent to the administration of cardiopulmonary resuscitation . . . unless there is consent to the issuance of an order not to resuscitate as provided in this article." N.Y. PUB. HEALTH LAW § 2962(1) (McKinney 1993).

<sup>19</sup> See George Annas, *New York's Do-Not-Resuscitate Law: Bad Law, Bad Medicine, and Bad Ethics*, in *LEGISLATING MEDICAL ETHICS: A STUDY OF THE NEW YORK DO-NOT-RESUSCITATE LAW* 141, 149 (Robert Baker & Martin A. Strosberg eds. 1995) (concluding that New York's DNR laws are unnecessary and ill-advised).

<sup>20</sup> See Boozang, *supra* note 17, at 25, (citations omitted). See, e.g., N.Y. PUB. HEALTH LAW § 2962 (McKinney 1993).

gies.<sup>21</sup> Traditionally, the patient relied on the professional judgment of physicians.<sup>22</sup> Today, ideally, the medical model is patient-driven, and thus when patient wishes are communicated or discerned, should be directive.<sup>23</sup> As a result of these changes, physicians and other health-care workers often administer CPR in situations they feel its use is contraindicated. Physicians make decisions to use or withhold CPR while influenced by the fear of litigation, inappropriate or unclear guidelines, or the misguided directions of the patient or his family. These influences together with additional extraneous factors cause many physicians' objective judgements to become clouded by factors other than the patient's best interests.<sup>24</sup> This often results in the contraindicated application of CPR.

As the medical community became increasingly aware of the harms that can be caused by the contraindicated use of CPR, physicians began to make decisions regarding the application of CPR either without informing the patient or acting against his direc-

<sup>21</sup> See Kate McMillan, *Pre-Directives: Paper Swords and Shields*, 37 THE ADVOCATE, May 1994, at 10 (discussing this shift in power as a result of the Supreme Court's recognition of patients' rights grounded in the right to privacy in *Quinlan* and *Cruzan*; Congress' enactment of the Patient Self Determination Act (PSDA), and the proliferation of pre-directive statutes in all states). See also *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1461 (W.D. Wash. 1994) (stating that "squarely faced with the issue, the Supreme Court would reaffirm Justice Rehnquist's tentative conclusion in *Cruzan* that a competent person has a protected liberty interest in refusing unwanted medical treatment. . ."), *rev'd.*, 49 F.3d 586 (9<sup>th</sup> Cir. 1995). See generally Symposium, *Physician-Assisted Suicide: Facing Death After Glucksberg and Quill*, 82 MINN. L. REV. 885 (1998) (presenting different facets of the physician-assisted suicide debate). See generally David Orentlicher, *The Alleged Distinction Between Euthanasia and the Withdrawal of Life-Sustaining Treatment: Conceptually Incoherent and Impossible to Maintain*, 1998 U. ILL. L. REV. 837 (discusses several justifications for euthanasia, including the autonomy of the patient).

<sup>22</sup> See JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 2, 29 (1984) (citing Alasdair MacIntyre, *Patients as Agents*, in PHILOSOPHICAL MEDICAL ETHICS: ITS NATURE AND SIGNIFICANCE 197, 205 (Stuart F. Spicker et al. eds., 1977) (discussing the changes in how doctors and patients communicate with each other). See generally Orentlicher, *supra* note 21.

<sup>23</sup> See KATZ *supra* note 22, at 84 (explaining how doctors should talk with their patients). But see Smith, *supra* note 5, at 1-2 (stating that "When medical treatment is deemed 'futile,' it frees the physician from the moral, medical, and legal duty to provide such treatment"). See generally EDMUND D. PELLEGRINO & DAVID C. THOMASMA, FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE 99-110 (Oxford Univ. Press 1988) (discussing the relationship between patients and physicians and suggesting several characteristics of patients which foster a better relationship).

<sup>24</sup> Smith, *supra* note 5, at 3 (discussing extraneous factors which may influence physicians' CPR determinations).

tions.<sup>25</sup> These decisions often took the form of "slow codes," which directed responding personnel to deliberately act in a manner which will not be effective in resuscitating the patient.<sup>26</sup> Slow codes were merely attempts by physicians to shield themselves from litigation that could arise from an outward or written order calling for the inaction of hospital personnel.<sup>27</sup>

This article will demonstrate that if autonomy or self-determination is to be more than a poetic principle, with clinical application to patients in end-of-life illnesses, it must be validated by closer levels of communication between patients and their health care providers *before* serious debilitating illnesses occur, which all too often block rational thinking by the patient, his family, or surrogate decision makers.<sup>28</sup> Such forthright communication and ultimate decision-making before a medical crisis is a simple and direct solution. There is no need whatsoever to deal with euphemistic coding or, for example, tests of substituted judgment or other artifices if patients articulate their life goals and medical wishes through execution of advance directives. Sadly, without this, patient autonomy must yield to physician autonomy<sup>29</sup> – yet, an autonomy shaped hopefully by compassion<sup>30</sup> and by standards of sound professional judgment regarding futile medical treatment<sup>31</sup> and – when challenged – submitted to review ideally by hospital ethics committees or, failing that, the courts.<sup>32</sup>

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<sup>25</sup> See generally Marsha D. M. Fowler, *Slow Code, Partial Code, Limited Code*, 18 HEART & LUNG 533, 533 (1989) (discussing critical factors to be considered in determining whether or not CPR or DNR is appropriate).

<sup>26</sup> See *id.*

<sup>27</sup> See *id.* at 533-34

<sup>28</sup> See generally Joan Teno et al., *Advance Directives for Seriously Ill Hospitalized Patients: Effectiveness with the Patient Self-Determination Act and the SUPPORT Intervention*, 45 J. AM. GERIATRICS SOC'Y 500 (1997) [hereinafter *Advance Directives*] (concluding that physician–patient communication has not been "substantially enhance[d]" by advance directives, the PSDA or SUPPORT).

<sup>29</sup> See Donald J. Murphy & Thomas E. Finucane, *New Do-Not-Resuscitate Policies: A First Step in Cost Control*, 153 ARCHIVES INTERNAL MED. 1641, 1644 (1993) (quoting D. P. Schuster, *Everything That Should Be Done—Not Everything That Can Be Done*, 145 AM. REV. RESPIR. DIS. 508, 508-09 (1992)).

<sup>30</sup> George P. Smith, II, *Stop in the Name of Love!*, 19 ANGLO-AM. L. REV. 55 (1990).

<sup>31</sup> See Smith, *supra* note 5 (defining medical futility and discussing factors surrounding futility determinations).

<sup>32</sup> See generally George P. Smith II, *The Ethics of Ethics Committees*, 6 J. CONTEMP. HEALTH L. & POL'Y 157 (1990) (predicting the betterment of hospital ethics committees as decision-makers as delivery facilities adopt more comprehensive and ethical programs).

While it is always the preferred course – and the one advocated by the American Medical Association<sup>33</sup> – to test the standard of futility according to individual patient values and goals, practice has shown physicians simply do not discuss routinely CPR with their adult patients who are admitted for medical and surgical care.<sup>34</sup> Indeed, there is a fuller discussion of DNR with AIDS and cancer patients than with patients without diseases with poor prognoses (e.g., coronary artery disease or cirrhosis).<sup>35</sup> Similarly, in order to avoid ambiguities in actual DNR orders, procedure specific orders should be given – with full documentation of the rationale for the order being set out.<sup>36</sup>

It will be seen as well that legislative directives which seek to furnish formal procedures governing decisions not to resuscitate are undesirable, this because of the rigid codification of standards that do not take into account the reasonable medical judgments that vary with individual patient etiologies and prognoses as well as the flexibility built into the doctrine of medical futility. Patient self-determination can be more readily validated and sustained by and through an alliance with personal physicians and health care providers instead of legislators.

## I. FRAMING THE CURRENT SOCIAL DEBATE

Three central questions shape the continuing societal debate, not only about the use but the limitation of life-sustaining treatments. They are: (1) Is there a limit to the obligation of medicine to save or prolong life; (2) When decisions are made, whose views and value systems control; and (3) Under what circumstances is there a recognition that the benefits of treatment are outweighed by the burdens?<sup>37</sup> Not only do these questions control the present de-

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<sup>33</sup> See Bernard Lo, *Unanswered Questions About DNR Orders*, 265 JAMA 1874 (1991) (noting that AMA guidelines respect patients' choice regarding CPR). See COUNCIL, *supra* note 14, at 1870-71 (upholding the Council's position on the appropriate use of CPR and DNR orders).

<sup>34</sup> See Lo, *supra* note 33, at 1875.

<sup>35</sup> See *id.*

<sup>36</sup> See James A. Mittelberger, et al., *Impact of a Procedure-Specific Do Not Resuscitate Order Form on Documentation of Do Not Resuscitate Orders*, 153 ARCHIVES INTERNAL MED. 228 (1993) (describing problems caused by inadequate documentation of DNR orders and proposing a standard procedure and form).

<sup>37</sup> See Jessica H. Muller, *Shades of Blue: The Negotiation of Limited Codes by Medical Residents*, 34 SOC. SCI. MED. 885, 896 (1992) (examining the use of partial and slow resuscitation attempts).



bate of the central issue, they structure the overall cultural framework in which resident physicians negotiate limited codes.<sup>38</sup>

In the absence of a written Do Not Resuscitate Order, it is standard hospital practice to require resuscitation for patients suffering a cardiopulmonary arrest and force them, in essence, to die in a code.<sup>39</sup> For the house staff physicians and interns in most hospitals, a DNR order in a patient's medical record lingering near death typically limits the type of medical assistance provided to the patient when he approaches death itself. On the contrary, the absence of a DNR order obligates the residents to approach any and all complications aggressively – treating the patient as though he were acutely ill and not dying.<sup>40</sup> The practical result of a situation of this nature is that the interns may very well expect to invest considerable time – in the middle of the night – “working up” either a very sick patient or coding one who is dying. The consequence of this is that the interns are diverted from their other hospital tasks and patient supervisions. Not only are such actions a waste of time and energy, they are not cost effective.<sup>41</sup>

When there are no demonstrable benefits to a medical intervention that maintains an expiring patient other than the act of survival itself, the best interests of the patient may not be served by resuscitation.<sup>42</sup> Accordingly, in those cases where a physician – more likely a resident, but occasionally an attending – is convinced of the futility or potential harm of further treatment, an intermediate code may be negotiated. This action may well have the effect of over-riding the wishes of the patient, family or even private or attending physicians, but allows the resident physician a convoluted way to avoid hospital policies. Stated otherwise, such a course of action, “allow[s] them a means of restricting their therapeutic activity when they confront[ed] the possibility of having to provide treatment they not only [think is] futile but could also inflict significant harm on the patient.”<sup>43</sup> The intermediate or limited code has the ultimate effect, then, of providing a means by which resident hospital physicians guard themselves, not only against in-house disciplinary action and legal liability but also control as well

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<sup>38</sup> See *id.*

<sup>39</sup> See *id.* at 894.

<sup>40</sup> See *id.* at 895.

<sup>41</sup> See *id.*

<sup>42</sup> See *id.* at 894.

<sup>43</sup> See *id.*

the extent to which they are forced to pursue futile drains of their time and hospital resources.<sup>44</sup> It is an artful euphemism, to be sure.

While it is understandable that hospitals have guidelines for physician behavior in the use of resuscitation, these codes of operating procedures fail to make allowance for patient variation and contemporary clinical practices.<sup>45</sup> Designed in response to unnecessary acts of resuscitation, DNR orders have given rise to yet another moral dilemma: the negotiation of slow codes. Stated otherwise, the slow or intermediate codes – while being a cultural response to unworkable circumstances arising in clinical practice – bring with their implementation and use a troubling ethical dilemma, they bypass the “very intent of the resuscitation guidelines: to honor the principle of patient (or surrogate) autonomy and to prevent physicians from making unilateral decisions about resuscitation by requiring a joint decision-making process.”<sup>46</sup>

In deciding whether to issue a DNR order, physicians have been found to rely unduly on a patient’s age and short-term prognosis – giving those two factors a weight that goes beyond their actual ability to predict life expectancy and quality of life.<sup>47</sup> In a study of 6,802 seriously ill patients, with illnesses such as coma, heart failure and cancer – with an average life expectancy of six months – some interesting findings were made.<sup>48</sup> First, compared with other medical specialists, surgeons waited nearly twice as long to write a DNR for a very sick patient while intensive care specialists and lung specialists were most likely to issue a DNR and cardiologists the least likely. With age as a factor in the issuance of DNR orders, it was found that only twenty-two percent of the patients under age fifty-five had DNR orders compared with fifty-six percent of those over 85. DNR orders were written most rapidly for patients older than seventy-five.<sup>49</sup>

All too often, ambiguities are found in DNR orders. A rather simple effort to issue a procedure specific DNR order and include

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<sup>44</sup> See *id.* at 895.

<sup>45</sup> See *id.* at 896.

<sup>46</sup> *Id.*

<sup>47</sup> See Rosemarie B. Hakin et al., *Factors Associated with Do-Not-Resuscitate Orders: Patient Preferences, Prognoses, and Physicians’ Judgments*, 125 ANNALS INTERNAL MED. 284, 292 (1996) (reporting on a study examining patient’s preferences for resuscitation and the frequency and timing of DNR orders).

<sup>48</sup> *Id.* at 284.

<sup>49</sup> *Id.* at 288.

the rationale for the order has been found to be an effective way to lessen both confusion and eliminate ambiguity.<sup>50</sup>

## II. UTILIZING CODES

When there are no orders written which specify what resuscitative measures should be taken with particular patients, hospital policies may well dictate that a full code should be called for, in other words, resuscitation is initiated.<sup>51</sup> Yet, circumstances may arise where it is just as appropriate – instead of calling a code – to initiate minimal resuscitative measures which do not rise to the level of being a full code and might be termed a “short code.”<sup>52</sup> This type of code is sometimes referred to as a *show code* and allows the health care personnel to initiate resuscitation and then proceed to stop their actions either after a few tried or a period of time predetermined.<sup>53</sup> This code is taken largely as a symbolic gesture designed to re-assure or placate the family of a patient – or the health care personnel, themselves – that “everything was done.”<sup>54</sup>

The *show, soft, slow, partial, limited* or *light blue* codes are all considered intermediate codes. Each designation conveys pertinent information concerning not only the type, but also the extent of response to be followed in the event of a patient suffering cardiopulmonary arrest. Thus a partial, limited, or soft code is taken commonly to set forth those circumstances where either drugs

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<sup>50</sup> See Mittelberger et al., *supra* note 36, at 231 (providing an investigation of the advantages of a procedure—specific and rationalized DNR order). See also Ezebiel J. Emmanuel, *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 JAMA 2460 (2000) (reporting a survey of 988 terminally ill patients during 1996 and 1997, where it was found that a majority of the respondents (60.2%) held the opinion that euthanasia and physician-assisted suicide should be available to Americans—with 10.6% of them, concluding they would consider these choices for themselves).

<sup>51</sup> See Felice Quigley, *Legalities of the No Code/Slow Code*, PENN. NURSE, Oct. 1988, at 15 (discussing liability for failure to follow hospital policy on codes). See also Judith Wilson Ross & Deborah Pugh, *Limited Cardiopulmonary Resuscitation: The Ethics of Partial Codes*, 14 QUALITY REV. BULL. 4.4 (1988).

<sup>52</sup> See Quigley, *supra* note 51, at 15. (discussing nurses' predicament when hospital staff neglects to clarify patients' code status).

<sup>53</sup> Interview with Sarah Shannon, Ph.D., R.N., Biobehavioral Nursing & Health Systems, University of Washington, in Seattle, Washington (Dec. 9, 1997).

<sup>54</sup> See Muller, *supra* note 37, at 890, 896 (discussing the negotiation of “slow codes” and “show codes”). See also John F. Peppin, *Physician Neutrality and Patient Autonomy in Advance Directive Decisions*, 11 ISSUES L. & MED. 13, 20 (1995).

might be administered without chest compressions or where resuscitation initiated but drugs or intubation would be withheld.<sup>55</sup>

Very often the uses of intermediate codes arise from informal arrangements negotiated verbally, often at night, between residents and nurses who reach an agreement – before a patient goes into cardiac arrest – regarding the courses of action or inaction to be taken. Attending physicians are sometimes consulted – with the ultimate decision regarding the use of a limited code being negotiated between the attending physician and the house staff. Although usually not formalized in writing, occasionally the stated medical reasons for selecting one resuscitative technique over another were in fact written in the patient's record. Clearly, then, intermediate codes are little more than clinical deviations from established hospital protocols and regulations. As such they are not easily observed nor acknowledged publicly.<sup>56</sup>

#### A. Types of Partial Codes

Medical realities and patient desires shape the parameters for issuance of partial codes. It is within this spectrum that marked confusion and disagreement occur primarily because of a failure by hospital personnel to differentiate partial codes according to their intents and purposes. Thus, it is essential to first distinguish between partial codes for patients who are monitored and those who are not.<sup>57</sup> Then, distinctions must be made between patients with and without specific medical conditions (e.g., chronic ob-

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<sup>55</sup> See *id.* Dr. John Goldenring has suggested that four "shades" of code blue are used clinically. Under a Dark Blue (or Full) Code, all possible measures are undertaken by a resuscitation team until it becomes clear that resuscitation is no longer possible. A Navy Blue Code calls for resuscitation, with the patient deserving sodium bicarbonate and one dose of cardiotoxic medication and possibly one defibrillation. A Sky Blue Code allows resuscitation to be performed, and sodium bicarbonate to be given, but no cardiotoxic drugs are administered. Finally, a Light Blue Code does not allow for the use of drugs – with cardiopulmonary resuscitation alone being performed on those patients "until the staff (who do not wish to resuscitate) can find an attending physician who will (it is hoped) call off the effort." John Goldenring, *Correspondence*, 300 NEW ENG. J. MED. 1052, 1058 (1979).

<sup>56</sup> Muller, *supra* note 37, at 890. Some physicians have even ordered slow codes when they are in disagreement with a patient's request for resuscitation. See John F. Peppin, *Physician Neutrality and Patient Autonomy in Advanced Directive Decisions*, 11 ISSUES L. & MED. 13, 20 (1995). See also Lo, *supra* note 33, at 1875 (noting the physicians' use of limited or partial DNR orders without considering the patient's wishes).

<sup>57</sup> Ross & Pugh, *supra* note 51, at 6.

structive pulmonary disease) which – in the event of full codes – may result in complications such as ventilator dependence.<sup>58</sup>

Partial codes may be distinguished, additionally, by the particular intent of the orders. The question is then: are the code orders being motivated by patient autonomy or by a health care provider's standard of beneficence? While autonomy, the patient's right to direct the course of medical treatment consistent with his life values, is acknowledged not every patient (or family) preference can or should be followed. Under the principle of beneficence, a health care provider must ascertain whether his actions contribute to a patient's well being. Thus, a conflict often arises when these two foundation principles come into play.<sup>59</sup>

There are essentially four situations in which partial codes may be written. The first arises when, for example, a partial code (e.g., "basic CPR only") is ordered as a result of a family refusal to consent to a DNR order. Most often, the physician is responding in such a case to what is believed to be an irrational family response in the first instance. Such an order may also be given in writing when discussion of approaching death with either the patient or the family is infeasible; yet the attending physician wishes to convey an obviously deceptive impression "that all that can be done is being done." Because of external problems in such a situation, then, a preferred DNR cannot be given. Yet, because the physician has determined that the best medical interests of the patient will be served by no resuscitative effort, a partial code may be ordered. Although such a use is motivated properly by beneficence, issuing a partial code under these circumstances is considered – under most circumstances – to be unethical.<sup>60</sup>

A second type of partial code is seen in cases where patients are on monitors. Here, for example, a "chemical code only" (or the use of cardiac drugs) is most commonly ordered when either a patient or his family has requested a DNR order or consented to its issuance. Because the physician, and even possibly the patient

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<sup>58</sup> See *id.* at 7. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that "partial codes" and "slow codes" may be used interchangeably. THE PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH DECIDING TO FOREGO LIFE-SUSTAINING TREATMENTS (1983). Yet, others consider partial codes as either a sub-category or a totally different form of "slow codes." See Ross & Pugh, note 51, at 4.

<sup>59</sup> See Ross & Pugh, *supra* note 51, at 6-7.

<sup>60</sup> See *id.* at 7.

and/or the family, are of the opinion that either the patient's actual condition or present quality of life are stabilized to such a degree that desirable efforts should be pursued to prevent an actual arrest, at the same time there is an understanding not to reverse it if it were in fact to occur. Thus, in a case of this nature, preventing an arrest is sought by simply treating pre-arrest symptomatology.<sup>61</sup>

When the patient or family expresses an unambiguous and reasoned decision not to allow ventilator use to prolong life, a third situation arises where a partial code such as – “do not intubate” – may be written. Typically, this situation presents itself when the physician reveals to all concerned parties that because of the patient's condition (*e.g.*, chronic obstructive pulmonary disease) once respirator care is initiated, there will be little chance of weaning the patient from the respirator. Although the physician places reliance upon an accurate prognosis, the patient or family makes the actual decision for the code.<sup>62</sup>

The fourth and most difficult of all partial codes for health care providers is seen in cases where an order such as, “do not intubate,” is written at the request of a competent patient who, for personal reasons, does not wish specific parts of the code performed. Normally, the basis of these reasons is to be found in fears that the patient will become either a vegetable or an untubated appendage to a machine. Simply because a competent patient makes a request of this nature, does not mean it must be respected; if it does not comport with a sound medical judgment by a health care provider, it will not be executed. Beneficence will usually trump autonomy.<sup>63</sup>

The inherent problem with partial codes is that patients and their families simply fail to realize that there are not discrete elements in resuscitation plans. Thus, from a medical perspective, a patient should submit to full resuscitation or no resuscitation.<sup>64</sup> Medical realities ultimately dictate euphemistic requests for less than effective full treatment options will not always be followed.

When patient requests are made for a full resuscitative effort “except intubation and ventilation,” they are made normally without a full understanding that to undertake such an effort, intubation

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<sup>61</sup> *See id.*

<sup>62</sup> *See id.*

<sup>63</sup> *See id.* *See generally* PELLEGRINO & THOMASMA, *supra* note 23 (discussing health as the central aspect of all medical relationships and ventures).

<sup>64</sup> *See* Ross & Pugh, *supra* note 51, at 8.

for maximal oxygenation will normally be required as well as ventilator assistance necessary to stabilize the patient. If it is determined subsequently that ventilator support is required for the longer term, the patient may thereupon request the withdrawal of support.<sup>65</sup>

Similarly, when patients view CPR decisions, they may request – for example – chest massage and mask ventilation and nothing more. Such a decision fails to take into consideration the fact that CPR is a synergistic process – with each component building upon the effectiveness of other components. Thus, the first stage of CPR typically includes chest massage and artificial respiration – followed, if necessary, by defibrillation and finally cardiac drugs. While appearances might suggest the process is indeed severable, if the patient is in a monitored unit, cardiac drugs might well be used first, with defibrillation beginning before chest massage. For unmonitored patients, while resuscitation begins with chest massage and artificial respiration, it is because there is no other equipment really available. Resuscitative efforts that use equipment are recognized as more effective than either chest massage or artificial respiration.<sup>66</sup>

### III. FUTILITY AS AN OPERABLE STANDARD<sup>67</sup>

Legislative definitions may be proffered for what is a terminal medical condition and include incurable and irreversible conditions “within reasonable medical judgment,” which will either cause death “within a reasonable period of time” or merely extend the dying process.<sup>68</sup> Depending of course upon individual patient

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<sup>65</sup> See *id.* at 7 (explaining patient misconceptions of a full resuscitative effort).

<sup>66</sup> See *id.* at 7-8.

<sup>67</sup> Information in the ensuing two paragraphs is derived from George P. Smith II, *Terminal Sedation as Palliative Care: Revalidating a Right to a Good Death*, 7 CAMBRIDGE Q. HEALTHCARE ETHICS 382, 384 (1998) (citations omitted). Other treatments might include antibiotics, transfusions, and intensive care. See Lo, *supra* note 33 at 1874 (providing an example of a patient whose treatment would be considered medically futile). See Alan Meisel, *Pharmacists, Physician-Assisted Suicide, and Pain Control* 2 J. HEALTH CARE L. & POL’Y 211 (1999). Interestingly, the 106<sup>th</sup> Congress considered the Pain Relief Promotion Act of 1999 (H.R. 2260, S. 1272) in an attempt to amend the Controlled Substances Act and thereby promote pain management and palliative care without permitting assisted suicide and euthanasia. See Statements on Introduced Bills and Joint Resolution on Pain Relief Promotion Act of 1999, 145 Cong. Rec. 57, 527-82, 57, 532-34 (June 23, 1999).

<sup>68</sup> See WASH. REV. CODE ANN. § 70.122.020(9) (West 2000).

profiles and disease etiologies, medical judgment will vary regarding when specified conditions are considered terminal.

One approach to resolving this quandary is found in the wider acceptance of the doctrine of medical futility. By utilizing one of five operative standards under this doctrine, a physician could conclude that a patient's condition is indeed terminal and proceed to search a wide range of palliation options – with terminal sedation being a first order consideration. Accordingly, in cases where a cure is physiologically impossible, continued treatment is non-beneficial, a desired or positive benefit is unlikely to be achieved, a particular treatment option – although regarded as plausible – has yet to be validated, or a determination is made that a course of treatment is either quantitatively or qualitatively futile, a physician is freed ethically from pursuing further medical treatment.<sup>69</sup> Bolstered by wide professional approbation of the doctrine, then, physicians exercising their best medical judgment would be allowed to withhold CPR from patients in futile conditions, without actual consent.<sup>70</sup> This humane action would, of course, only be undertaken when it would be in the patient's best medical interests not to have a hopeless, non-qualitative existence continued.

The American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care allow resuscitation to be discontinued in pre-hospital (or field) settings when, after an adequate trial of advanced cardiac life support, the patient remains non-resuscitable.<sup>71</sup> Because of familial nonacceptance of field termination of unsuccessful out-of-hospital cardiac arrest, however, emergency medical services continue the medical charade of transporting pulseless patients to hospital emergency departments – knowing fully that such actions must be considered futile.<sup>72</sup> As a consequence, the significant neurologic damage asso-

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<sup>69</sup> See Smith, *supra* note 5, at 6 (identifying the clinical uses of the futility doctrine).

<sup>70</sup> See generally Tomlinson & Brody, *Futility and the Ethics of Resuscitation*, 264 JAMA 1276 (1990). See Leslie J. Blackhall, *Must We Always Use CPR?*, 317 NEW ENG. J. MED. 1281, 1284 (1987) (arguing that when CPR has no medical benefit a physician has no responsibility to provide it as a choice). See also Council *supra* note 14, at 1871 (updating the council's position on the appropriate use of CPR and Do-Not-Resuscitate orders).

<sup>71</sup> Theodore R. Delbridge et al., *Field Termination of Unsuccessful Out-Of-Hospital Cardiac Arrest Resuscitation: Acceptance by Family Members*, 27 ANNALS EMERGENCY MED. 649, 650 (1996) (citing American Heart Association, *Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care VIII: Ethical Considerations in Resuscitation*, 268 JAMA 2282, 2282-88 (1992).

<sup>72</sup> See *id.*



ciated with resuscitation by aggressive advanced life support, many questions remain open as to initial decisions to initiate the procedure in the first instance. A high patient price – with significant family distress – is quite often the end result of such efforts.<sup>73</sup>

The probability that resuscitative effort will provide more than a marginal benefit appears to be the emerging – and most acceptable – basis for determining whether to initiate aggressive treatment.<sup>74</sup> Under this standard, cardiopulmonary patients who are near death and unlikely to survive after CPR is administered are clearly an identifiable group who would be benefited marginally by such resuscitative efforts.<sup>75</sup> In essence, under this standard, a clear example is seen of the codification of a futile treatment and a validation of the medical principle of *triage*.<sup>76</sup> For example, CPR has been labeled a futile act for patients with metastatic cancer – this simply for the reason that survival after CPR is reported to be zero.<sup>77</sup>

#### A. The Ineffectiveness of Advance Directives

In three recent studies of the value and effectiveness of advance directives in the treatment of end of life cases, it was shown rather conclusively that directives such as living wills and other written proxies rarely have much impact on the care of dying patients.<sup>78</sup> Sadly, the studies disclosed that only about one-fifth of patients write down their treatment preferences in the form of an

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<sup>73</sup> See Michael Callahan & Christopher D. Madsen, *Relationship of Timeliness of Paramedic Advanced Life Support Interventions to Outcome in Out-of-Hospital Cardiac Arrest Treated by First Responders with Defibrillators*, 27 ANNALS EMERGENCY MED. 638, 638 (1996).

<sup>74</sup> See Murphy & Finucane, *supra* note 29, at 1645 (citations omitted).

<sup>75</sup> See generally *id.* (citations omitted) (adding that the size of this group is unknown but believed to be quite large).

<sup>76</sup> See George P. Smith II, *Triage: Endgame Realities*, 1 J. CONTEMP. HEALTH L. & POL'Y 143, 146 (1985).

<sup>77</sup> See Lo, *supra* note 33, at 1874 (describing when CPR is considered medically futile). See also Lawrence J. Schneiderman & Nancy Jecker, *Futility in Practice*, 153 ARCHIVES INTERNAL MED. 437, 439 (1993) (suggesting that the medical community use a degree of quantitative analysis to achieve consensus on the definition of futile treatment); Tom Tomlinson & Diane Czlonka, *Futility and Hospital Policy*, HASTINGS CENTER. REP., May-June 1995, at 28 (discussing the development of hospital policies for futile resuscitation).

<sup>78</sup> See *supra* note 28; Joan M. Teno et al., *Do Advance Directives Provide Instructions That Direct Care?*, 45 J. AM. GERIATRICS SOC'Y 508 (1997); Joan Teno, et al., *The Illusion of End-of-Life Resource Savings with Advance Directives*, 45 J. AM. GERIATRICS SOC'Y 513 (1997).

advance directive and usually do not even tell their physicians of these actions. Accordingly, in approximately one third of these cases do documents of this nature find their way into the patient's medical chart.<sup>79</sup> Most directives were found to be too vaguely worded to be of any assistance in guiding specific decisions about medical treatment such as whether to try to resuscitate a gravely ill patient when his heart stops.<sup>80</sup>

One study reviewed the medical charts of 4,804 dying patients in five hospitals and found only 688 advance directives from 569 patients – with only 22 being specific enough to provide assistance to physicians with patient preferences. The other directives were only general expressions of a willingness to die rather than prolong dying through artificial means.<sup>81</sup>

The central purpose behind the promotion of advance directives was to enhance substantially a level of education and informative communication among physicians and their patients – all designed to resolve patient uncertainty over end of life treatments. These studies show conclusively that no discourse is being stimulated.<sup>82</sup> They re-enforce the notion that the physician is, by default, once again the main actor in the concluding drama of life.

#### IV. LEGISLATIVE ATTEMPTS TO CONTROL RESUSCITATION: AN EFFECTIVE STRATEGY?

As of 1994, only two states, New York and Georgia, have enacted statutes that furnish formal procedures governing decisions not to resuscitate.<sup>83</sup> Although the two laws differ significantly, the key standards of both are relatively similar,<sup>84</sup> and generally correspond to the resuscitation guidelines that are published by the American Medical Association and required in accredited hospitals.<sup>85</sup> Those guidelines direct that a physician intending to issue a

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<sup>79</sup> See Teno et al., *supra* note 28, at 507.

<sup>80</sup> See Teno et al., *supra* note 78, at 511.

<sup>81</sup> See *id.* at 509-10.

<sup>82</sup> See *id.* at 511-12. See also Barbara E. Cammer Paris et al., *Roadblocks to Do-Not-Resuscitate Orders: A Study in Policy Implementation*, 153 ARCHIVES INTERNAL MED. 1689, 1689-98 (1993) (analyzing a study which demonstrated that a lack of communication between attending physicians and attendants is a major obstacle to obtaining a DNR order); Walker, *supra* note 3.

<sup>83</sup> See N.Y. PUB. HEALTH LAW §§ 2960-79 (McKinney 1993); GA. CODE ANN. § 31-39-3 (1996); Ebell, *supra* note 4, at 1294.

<sup>84</sup> See N.Y. PUB. HEALTH LAW §§ 2960-79 (McKinney 1993). But see GA. CODE ANN. § 31-39-3 (1996). See also Ebell, *supra* note 4, at 1294-5.

<sup>85</sup> See generally Mooney, *supra* note 9, at 1032-33 (citations omitted).

DNR order must take several preliminary steps. First, he must "determine that the patient's death is so certain and so imminent that resuscitation would serve no purpose."<sup>86</sup> Second, he must obtain either the informed consent of the patient or the approval of the patient's family or surrogate.<sup>87</sup> If the patient is competent, the patient himself should decide whether to refuse resuscitation.<sup>88</sup> "If the patient is incompetent to make the decision, . . . the same family members who must consent to a post-mortem examination must approve entering a DNR order."<sup>89</sup> Next, the physician must ensure "[t]he patient's medical chart . . . [reflects both] . . . the decision not to resuscitate and the consent of the patient or family members."<sup>90</sup> Finally, the physician must review the decision daily.<sup>91</sup>

Despite their binding effect, a number of physicians sometimes choose unilaterally to disregard such DNR guidelines, and without consulting or obtaining approval from the patient's family or surrogate issue unwritten orders to medical personnel not to resuscitate severely and irreversibly demented, or incompetent and terminally ill patients.<sup>92</sup> Generally, such orders or slow code decisions are made when physicians believe strongly that resuscitation is not in the best interest of the patient, and the patient's family or surrogate disagrees.<sup>93</sup> The physician "may feel compelled by conscience to do secretly what [he] feels is right,"<sup>94</sup> or he may simply have concluded that it is "not worth the effort to effect [resuscitation] in the event of cardiac or respiratory arrest."<sup>95</sup> In any event, the physician usually "pass[es] along the word" that the patient is to be slow coded, and nurses and other medical personnel are then expected to take their time in responding to the patient's arrest, or merely to pretend to take appropriate resuscitative measures.<sup>96</sup>

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<sup>86</sup> *Id.* at 1034.

<sup>87</sup> *See id.*

<sup>88</sup> *See id.*

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *See id.* at 1034-35.

<sup>92</sup> *See* John O. Neher, *The "Slow Code": A Hidden Conflict*, 27 J. FAM. PRAC. 429, 429 (1988) (discussing the policy concerns of not following the resuscitation orders as written in hospital records).

<sup>93</sup> *See id.*

<sup>94</sup> *Id.*

<sup>95</sup> Smith, *supra* note 5, at 5.

<sup>96</sup> David Anderson, *Death and Dying: Ethics at the End of Life*, RN, Oct. 1988, at 42, 46.

### A. The New York Approach: An Analysis

By legislating the authority to issue DNR orders to clinicians, the New York state legislature hoped it could increase the level of care to seriously ill patients and the level of doctor-patient communication. The New York Task Force and the legislature held the opinion that if they reduced the liability of clinicians, DNR orders would become more prevalent and controlled, thereby eliminating the need for "slow codes."

#### 1. Statutory Provisions

On April 1, 1988, New York's "do not resuscitate" law, which was signed into law by Governor Mario Cuomo, became effective.<sup>97</sup> The law "establishes a presumption in favor of the patient's implied consent to CPR, [as well as] the lawfulness of a DNR order if the order is issued in compliance with the [statute]"<sup>98</sup> "The law allows [competent] adult[s] . . . to authorize . . . DNR order[s] in conjunction with [their attending] physician."<sup>99</sup> "Where [the patient] lacks capacity, or . . . is a minor, the law allows for the appointment of a surrogate" whose judgment may be substituted for that of the patient.<sup>100</sup> Interestingly, when no surrogate is available, a DNR order is limited to those cases where "to a reasonable degree of medical certainty, resuscitation would be medically futile."<sup>101</sup>

The law limits specifically the application of DNR orders to the withholding or withdrawal of CPR.<sup>102</sup> The law also requires that each hospital establish a mediation system for the purpose of

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<sup>97</sup> N.Y. PUB. HEALTH LAW § 2960 (McKinney 1993).

<sup>98</sup> Susan M. Golden, Comment, *Do Not Resuscitate Orders: A Matter of Life and Death in New York*, 4 J. CONTEMP. HEALTH L. & POL'Y 449, 451 (1988).

<sup>99</sup> *Id.*

<sup>100</sup> *Id.* If there are no qualified surrogate decision-makers available, an attending physician or hospital may initiate judicial proceedings for a judgment authorizing the issuance of an order not to resuscitate. See N.Y. PUB. HEALTH LAW § 2976(1) (McKinney 1993). This action is merited in those cases "where the patient has a terminal condition, is permanently unconscious, or resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of the resuscitation." *Id.* It is provided further that this DNR order not be inconsistent with the patient's religious and moral beliefs and be in regard to the patient's wishes or alternatively—made in his best interests. See *id.* § 2976.

<sup>101</sup> N.Y. PUB. HEALTH LAW § 2966 (McKinney 1993).

<sup>102</sup> See Golden, *supra* note 98. See also BARRY R. FURROW ET AL., *BIOETHICS: HEALTH CARE LAW AND ETHICS* 293-96 (3d. ed. 1997) (discussing New York state laws on DNRs).

mediating disputes regarding the issuance of DNR orders<sup>103</sup> and requires further that if the dispute has not been settled within seventy-two hours, the participants must be notified of their right to judicial appeal.<sup>104</sup> Finally, the law extends immunity from criminal prosecution, civil liability, and charges of unprofessional conduct to all hospital personnel and persons acting in good faith under the law.<sup>105</sup>

## 2. New York State's Need for Legislation

Prior to the adoption of this law, New York developed a body of common law, which limited the right of surrogates to refuse life-sustaining treatment on behalf of incapacitated patients who had not previously expressed their desire not to be resuscitated.<sup>106</sup> Given the fact that both prior to and after the enactment of the "do not resuscitate" law patients were involved in DNR decisions only thirteen to twenty-eight percent of the time (incapacity required surrogate involvement in the remainder), it is apparent why New York decided to legislate a change to the common law.<sup>107</sup> The DNR legislation served as a mechanism for the legislature to provide for the legal authorization of surrogate decision-making in a state that had, heretofore, and continues to this day, to have a judicial tradition of opposition to substituted judgment.<sup>108</sup> So strong has been this opposition that since 1990 with the case of *Cruzan v. Director, Missouri Dept. of Health*,<sup>109</sup> New York remains only one of two states requiring clear and convincing evidence before life-sustaining measures, once commenced, may be terminated.<sup>110</sup>

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<sup>103</sup> See N.Y. PUB. HEALTH LAW § 2972(1)(a) (McKinney 1993).

<sup>104</sup> See N.Y. PUB. HEALTH LAW § 2972(3) (McKinney 1993).

<sup>105</sup> See N.Y. PUB. HEALTH LAW § 2974 (McKinney 1993).

<sup>106</sup> See Russell S. Kamer & John A. McClung, *New York's Do-Not-Resuscitate Law: Burden or Benefit?*, in *LEGISLATING MEDICAL ETHICS: A STUDY OF THE NEW YORK DO-NOT-RESUSCITATE LAW 227*, 230 *passim* (Robert Baker et al., eds., 1995) (using *Matter of Storar*, 52 N.Y. 2d 517 (1988) as an example).

<sup>107</sup> See *id.* at 230-31.

<sup>108</sup> See *id.* at 230 (citing *Matter of O'Connor*, 72 N.Y. 2d 517 (1988) as an example of a decision limiting the use of substituted judgment).

<sup>109</sup> 497 U.S. 261 (1990) (holding that Missouri could constitutionally require clear and convincing evidence of an incompetent's wishes to withdraw life-sustaining treatment).

<sup>110</sup> See Annas, *supra* note 19, at 149. Missouri is the other state. See *id.*

### 3. Overall Successes and Failures

The New York statute has not only been found to be successful in limiting the use and need for slow codes – in large part by granting express immunity from suit to health care workers utilizing them in good faith<sup>111</sup> – but it has advanced and underscored the bioethical ideal of a shared physician decision-making process of deliberation.<sup>112</sup> Yet, this whole process has – at the same time – been found to create confusion which, in turn, diminishes the very humanism of the DNR decision, increases futile CPR because of delays in the issuance of DNR orders, and gives rise to “over-interpretations” under the controlling statute.<sup>113</sup>

No doubt, its central flaw, however, is the presumption that all residents of New York have, in medical emergencies, consented to CPR.<sup>114</sup> As seen, however, CPR is not always beneficial<sup>115</sup> and – when contraindicated – can result in excessive patient suffering as well as draining medical expenses for maintenance of life thereafter.<sup>116</sup> Inasmuch as the principle of informed consent to medical treatment is recognized and applied, it is difficult to understand why a forced exception to this doctrine is made for CPR under the statute. There is little, if any, reason to have a statutory classification of DNR orders as separate and distinct from all other orders. Indeed, all orders should be held to identical standards for issuance.

### 4. Accreditation Policies under JCAHO

Complementing the New York DNR statute, the Joint Commission on Accreditation of Health-Care Organization (JCAHO) in 1988, changed its accreditation requirements – all in an attempt to encourage bioethical reforms with regard to the overall use of DNR orders.<sup>117</sup> The reforms were codified as professional stan-

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<sup>111</sup> See N.Y. PUB. HEALTH LAW § 2974 (McKinney 1993).

<sup>112</sup> See Robert Baker et al., *The 1988 DNR Reforms: A Comparative Study of the Impact of the New York DNR Law and the JCAHO Accreditation Requirements*, in *LEGISLATING MEDICAL ETHICS: A STUDY OF THE NEW YORK DO NOT RESUSCITATE LAW* 263, 270.

<sup>113</sup> See *id.* at 281-84. See also FURROW ET AL., *supra* note 102, at 295 (noting that New York's law may even require CPR in cases where it is inappropriate).

<sup>114</sup> See Annas, *supra* note 19, at 148, 150-51.

<sup>115</sup> See *id.* at 151.

<sup>116</sup> See *id.* (estimating that CPR will cost three to five thousand dollars).

<sup>117</sup> See Baker et al., *supra* note 112, at 263 (discussing the self-regulative and legislative approaches to bioethical reform).

dards to be enforced subsequently as requirements for accreditation.<sup>118</sup> They permit, essentially, each medical institution to determine for itself how best to document patient decision-making in health care matters, protect patient's rights, and a number of related matters.<sup>119</sup> Predictably, the rather wide latitude permitted by the JCAHO accreditation requirements has led to an assortment of different and sometimes inconsistent policies.<sup>120</sup>

### 5. Clinical Effectiveness

The objectives of both the New York DNR law and the JCAHO accreditation requirements to enhance and strengthen cooperative involvement among patients and their health care providers as to disclosure, documentation and consent in critical matters of health care services, have largely been achieved.<sup>121</sup> There was unanimous agreement among respondents to one major study published in 1995 of this issue which found that subsequent to these two 1988 legislative and administrative reforms, there was "substantial increase in the likelihood that DNR orders would be *discussed* with patients at risk for CPR, and with their families, and that any DNR orders implemented would *have patient-family consent*."<sup>122</sup> The study determined that the likelihood of direct discussions with patients doubled after the 1988 reforms. With specific reference to the use of "slow codes" and other covert, undocumented orders, DNRs "decreased almost to the point of non-existence."<sup>123</sup>

While it was found that the New York and JCAHO reforms were equally effective, the 1995 study demonstrated – with regard to the negative effects of the reforms – significant differences between the legislative and the professionally mandated models.<sup>124</sup> It showed specifically that physicians in the state of New York perceived the legally mandated DNR reform as delaying DNR orders, increasing futile CPR, and diminishing the humanism of the actual

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<sup>118</sup> See *id.* at 280.

<sup>119</sup> See *id.* at 287.

<sup>120</sup> See *id.* (giving examples of the range of policies).

<sup>121</sup> See *id.* at 270-82.

<sup>122</sup> *Id.* at 270.

<sup>123</sup> See *id.* But see Paris et al., *supra* note 82, at 1694 (citing R. S. Kamer et al., *Effect of New York State's Do-Not-Resuscitate Legislation on In-hospital Cardiopulmonary Resuscitation Practice*, 88 AM. J. MED. 108, 108-11 (1990) which found no significant decline in resuscitative attempts following the enactment of the 1988 DNR legislation in New York).

<sup>124</sup> See Baker et al., *supra* note 112, at 280-81.

DNR decision.<sup>125</sup> Nevertheless, the study found that the physicians practicing under them perceived the JCAHO reforms as “unequivocally beneficial.” It suggested further that this difference in perceptions between the two groups was not the consequence of minor disagreements in the demands the reforms placed upon the physicians, but rather the manner in which they were being implemented.<sup>126</sup>

By mandating that the JCAHO accreditation reforms be implemented by the staffs of the physicians’ own institutions where they are credentialed, there is a much greater likelihood of the reform policies being implemented. This is a sound marketing strategy, since the affected health care providers are allowed, under the reforms, to revise or even revoke any part of the accreditation policies found to be unworkable.<sup>127</sup> Indeed, one of the clearest lessons to be drawn from New York’s experience with its DNR law is that when attempting to regulate professional conduct through legislation every effort should be made to preserve and utilize the professional self-regulatory process.<sup>128</sup>

Perhaps one of the most startling conclusions drawn from the 1995 study of the 1988 New York DNR reforms was that misinterpretations by New York clinical practitioners working under the actual statute, accounted for “over-interpretations,” or in other words non-existent requirements.<sup>129</sup> Indeed, many of the most poignant objections to the provisions of the statute have been grounded in these clinical misreadings and over-interpretations.<sup>130</sup> Over-interpretations can also cause physicians to initiate futile attempts at resuscitation – all as a direct consequence of their attempts to comply with misread “requirements” of the DNR statute.<sup>131</sup> No doubt the medical community that the New York statute’s presumption of consent to CPR mandates resuscitative efforts are given to any patient without DNR orders sees the best illustration of this quandary in the persistent perception.<sup>132</sup>

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<sup>125</sup> See *id.* at 281-84.

<sup>126</sup> See *id.* at 287-96.

<sup>127</sup> See *id.* at 288.

<sup>128</sup> See *id.* at 293.

<sup>129</sup> See *id.* at 289.

<sup>130</sup> See *id.* at 290.

<sup>131</sup> See Kamer & McClung, *supra* note 106, at 230 (stating that the medical community misperceives the law as placing a new duty on physicians to resuscitate all patients).

<sup>132</sup> See *id.*



As might be expected, the New York DNR statute was shaped and written within a legal context; a context which clinicians have found foreign to their understanding of the statute's implementation. Put simply, legal rather than medical documentation was advanced as the template for surrogate DNR decisions.<sup>133</sup> In order to ensure compliance with the statute, hospitals have thus been forced to acquire legal representation. And, as a consequence of protecting their client hospitals from liability, the attorneys have, themselves, added to the law's "over-interpretation"<sup>134</sup> and no doubt enhanced their billable hours.

#### IV. CONCLUSIONS

The "implicit but rarely articulated question in resuscitative decisions" is "whether and when to [end] the [life] struggle against death."<sup>135</sup> As has been seen, coded resuscitative efforts are nothing but a subterfuge which all too often rob the patient at the end-of-life of dignity and autonomy yet protects family members and the assisting medical team from experiencing fully their own failures in preventing the patient's death.<sup>136</sup> Unable to undertake a surgical procedure with an assured statistical measure of, a coded patient becomes – in reality – little more than a metaphoric euphemism for a systemic failure of not only the patient himself, but of the medical establishment as well.<sup>137</sup>

Only by developing a common understanding of, and shared vocabulary for the dying process,<sup>138</sup> thereby promoting a free line of communication among all affected parties,<sup>139</sup> can inhumane resuscitative efforts be stopped and codes eliminated altogether. In the final analysis, "to understand a phenomenon, one must under-

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<sup>133</sup> "A surrogate shall express a decision consenting to an order not to resuscitate . . . in writing, dated, and signed in the presence of one witness eighteen years of age or older who shall sign the decisions . . ." N.Y. PUB. HEALTH LAW § 2965(4)(a) (McKinney 1993).

<sup>134</sup> See Baker et al., *supra* note 112, at 292-93. See generally Nancy Tecklenberg, Comment, *Medico-Legal Implications of "Orders Not to Resuscitate,"* 31 CATH. U. L. REV. 515 (1982) (analyzing several New Jersey, Massachusetts and New York cases regarding orders not to resuscitate).

<sup>135</sup> Kathleen Nolan, *In Death's Shadow: The Meanings of Withholding Resuscitation*, 17 HASTINGS CENTER REP. 9, 11 (1987) (discussing the symbolic nature of resuscitation and the meaning of death).

<sup>136</sup> See *id.*

<sup>137</sup> See *id.*

<sup>138</sup> See *id.* at 14 (discussing the confusion over terminology and vocabulary).

<sup>139</sup> See *supra* note 78.

stand its language and its symbols.”<sup>140</sup> Heavy emotional connotations flow from such terms as “persistent vegetative state,” “CPR,” and “do not resuscitate.” Because of the varied connotations – and, indeed, ambiguities – arising from the use of these words, transmitting the precise information needed for a patient or his family to understand the consequences flowing from their use is fraught with misunderstanding.<sup>141</sup>

If a comprehensive acceptance and use of the doctrine of medical futility could be achieved as a pivotal measure to define when cardiopulmonary resuscitation should be withheld,<sup>142</sup> other aids and constructs could be developed for guiding humane decision-making in end-of-life cases. For example, greater utilization of and reliance upon hospital ethics committees could be promoted when confusion or disagreement arises among patients, their families, and attending physicians.<sup>143</sup> Fuller discussion of a patient’s code status before an episode of distress arises<sup>144</sup> together with unambiguous documentation<sup>145</sup> in the patient’s medical record of those medical reasons for selecting the particular techniques for resuscitation (or non-resuscitation, as the case may be) would also go far to dispel the need for slow or intermediate codes.<sup>146</sup>

As observed, a freer exchange of information and a wider level of consultation in conferences between the attending physicians and the nurses charged with caring for terminally ill or demented patients would go far to determine the parameters of the patient’s best interests in treatment or non treatment issues. Undocumented knowledge could, in turn, be learned about patient

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<sup>140</sup> Nolan, *supra* note 135, at 9.

<sup>141</sup> See Peppin, *supra* note 56, at 22-24 (showing that patients may not receive a neutral presentation of advance directives and that the wording of the information may significantly sway their decision).

<sup>142</sup> See N.Y. PUB. HEALTH LAW § 2966 (1) (McKinney 1993) (recognizing futility as the standard for issuing a DNR under New York statutory law.) See generally Steven Miles, *Futility and Medical Professionalism*, 25 SETON HALL L. REV. 873 (1995) (explaining what medical futility is and problems with its application by society).

<sup>143</sup> See Smith, *supra* note 32, at 158.

<sup>144</sup> See Paris et al., *supra* note 82, at 1695.

<sup>145</sup> See Miles, *supra* note 142, at 896.

<sup>146</sup> See generally Tom Tomlinson & Howard Brody, *Ethics and Communication in Do-Not-Resuscitate Orders*, 318 NEW ENG. J. MED. 43 (1988) (addressing the ambiguities in DNR policy and procedure). See also Mittelberger et al., *supra* note 36.

values and goals.<sup>147</sup> These conferences would allow the nurses and other health care members to share their reservations or questions about the physician's orders and promote an open discussion of views concerning, for example, the futility of continued treatment—thereby permitting an opportunity for nurses or others to remove themselves from compromising ethical situations before a medical emergency is presented.<sup>148</sup>

Even when all of this is said and done, there is a real concern that increased documentation and enhanced levels of communications among all affected individuals in a particular case may be inadequate to the task of curtailing unilateral decisions which have the effect of eviscerating the doctrine of informed consent for the patient or surrogate decision makers. To begin, even if legislatures or hospitals were to require physicians to be more compulsive about discussing and documenting the resuscitative preferences of patients and their families, little would change, because the conditions that foster slow codes would continue to exist.<sup>149</sup> Indeed, although physicians in general might become more acquainted with and more frequently document the personal values and wishes of patients and their families, those physicians willing to order slow codes in the first place would not likely be convinced by a simple conversation to provide resuscitative measures which they know will cause futile, cruel, and wasteful prolongation of life. Such physicians are compelled by their own consciences to do what they, and not patients' families or surrogates believe to be right.<sup>150</sup> Moreover, because the threat of litigation for malpractice and for violation of the doctrine of informed consent has apparently not precluded the use of physician-ordered slow codes,<sup>151</sup> there is little reason to conclude that the additional threat of litigation for failure to conform to the documented wishes of a patient's family will.

Neither, it seems, would increased communication alleviate the confusion and cynicism occasioned by slow code orders among

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<sup>147</sup> See Neher, *supra* note 92, at 430 (discussing the fact that physicians often "order" slow codes for patients despite having little or no knowledge of patient's goals, and knowing about the patient's life only during times of illness). See generally FURROW ET AL., *supra* note 102 (discussing the legal mechanisms used to ensure that CPR is not withdrawn or administered against the patient's wishes).

<sup>148</sup> See generally Mooney, *supra* note 9, at 1039-41 (citations omitted).

<sup>149</sup> See Neher, *supra* note 92, at 430 (highlighting the fact that changes to the requirements of physicians may fix some symptoms, but will not solve the overall problem).

<sup>150</sup> See *id.* at 429.

<sup>151</sup> See *id.* at 430.

health care personnel. Despite the opportunity to share their personal feelings of frustration, anger, fear, and helplessness with the physician, and to remove themselves from participation in actual slow code practices, nurses and other personnel will remain in the ethical hot seat by virtue of their knowledge that a slow code was ordered.<sup>152</sup> Unless they elect to report the physician to the hospital administration, ethics committee, or to the police, such personnel will expose themselves to the risk of liability for negligence.<sup>153</sup>

Because the past proposals for reducing the harms of slow code orders simply drive the dilemma further underground, an approach must be developed which attempts to eliminate the slow coding physician's very motive for deception.<sup>154</sup> Generally, as observed, the slow coding physician believes that withholding resuscitation is in the best interests of the patient, and undertakes to deceive the family or surrogate when he cannot persuade them to agree to authorize a DNR order.<sup>155</sup> The deception is necessary, he argues, because it is the only means by which to circumvent the decision of a recalcitrant family or surrogate who has been given primary responsibility for determining whether to withhold resuscitative treatment.<sup>156</sup>

By giving physicians the primary responsibility for making the decision to withhold resuscitative treatment from incompetent or terminally ill patients, however, legislatures and the medical community would substantially diminish the motivation for ordering slow codes in the first place.<sup>157</sup> Such a decision-shifting scheme would enable physicians to make openly and honestly the decisions they were trained to make, and would no longer require them to prescribe resuscitative measures that they deem to be futile, cruel or wasteful, or coerce them into committing secret breaches of the standard of care or violations of the informed consent doctrine.<sup>158</sup> In addition, because unilateral orders not to resus-

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<sup>152</sup> See Karen Ellis, *The Slow Code Dilemma*, REG. NURSE, June 1987, at 28, 29 (discussing how "slow codes" may leave nurses in uncertain legal and ethical quandaries).

<sup>153</sup> See generally BLACK'S LAW DICTIONARY 1032 (6<sup>th</sup> ed. 1991) (defining negligence).

<sup>154</sup> See generally Anderson, *supra* note 96, at 65.

<sup>155</sup> See *id.* at 46.

<sup>156</sup> See generally Mooney, *supra* note 9, at 1044-45 (discussing the duty of physicians to consent patient's guardians and family).

<sup>157</sup> See Smith, *supra* note 5, at 17-18.

<sup>158</sup> See *id.* See also E. Haavi Morreim, *Profoundly Diminished Life: The Casualties of Coercion*, 24 HASTINGS CENTER REP. 34, 35 (1994). See generally Steven H.

citate would not have to be issued in a deceptive manner, the confusion and cynicism among health care personnel regarding such orders would no doubt decrease.<sup>159</sup>

While the physician would have "primary" decision-making responsibility under the scheme, he would nevertheless retain a duty to inform the patient's family or surrogate of his decision and reasons thereof.<sup>160</sup> Such a duty protects the patient's autonomy and surrogate's authority, while making "the physician accountable for . . . decisions negligently made and those decisions not carefully documented."<sup>161</sup> Moreover, in order to ensure that the physician's values are not *improperly* imposed upon patients and their families, such parties would have the right to appeal, first to the hospital ethics committee, and later, if need be, to the judicial system.<sup>162</sup> The necessary task of the ethics committee and the courts would be to balance the personal values and rationale of the patient and his family in requiting resuscitation, against the societal interests in preventing futile, cruel and wasteful treatment.<sup>163</sup> If the adjudicating body determines that the rationale for resuscitation is reasonable and outweighs the gravity of prolonging the death of a dying or demented individual, then it should substitute its own judgment for that of the physician, and remove the treating physician from the case in order to prevent any subsequent slow code order.<sup>164</sup> Otherwise, deference should be given to the expertise of the physician and his unilateral decision not to resuscitate should be upheld.

Although it has been asserted that the New York Do-Not-Resuscitate Law has been effective as a means of codifying a communal approach to medical decision-making,<sup>165</sup> clinical evidence suggests that the same results can be achieved through institutional policy, thus making the burdensome provisions of the law "redundant, inefficient and unnecessary."<sup>166</sup> Legislative attempts to

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Miles, *Informed Demand for Non-beneficial Medical Treatment*, 325 NEW ENG. J. MED. 512 (1991) (discussing the conflict between the doctor and the patient's family over what is appropriate medical care).

<sup>159</sup> See Morreim, *supra* note 158, at 35.

<sup>160</sup> See Smith, *supra* note 5, at 18.

<sup>161</sup> *Id.* at 19.

<sup>162</sup> See *id.* at 18.

<sup>163</sup> See *id.* at 17-20.

<sup>164</sup> See *id.*

<sup>165</sup> See Kamer, & McClung, *supra* note 106, at 232-33.

<sup>166</sup> *Id.* See generally Alan Meisel et al., *Seven Barriers to End-of-Life Care: Myths, Realities, and Grains of Truth*, 24 JAMA 2495 (2000).

contour and then mandate standards of reasonable medical judgment are to be avoided – for they rob both patient and physician of their healing alliance. Institutional policies should be developed and maintained which center on the patient's (or, in the event of incompetence, the surrogate's) informed consent, as well as the education of health care workers with respect to the law.<sup>167</sup> These policies or guidelines must maintain a critical balance – they must set out the specific requirements for a properly issued DNR order without being so restrictive as to force physicians to return to the use of slow codes. If an institution creates or adopts a working definition of futility, it will – as seen – be instrumental in its efforts to maintain this balance. Additionally, acceptance of the futility doctrine can serve as an impetus for attaining macro economic utility in the distribution of health care resources.<sup>168</sup>

If the institutional guidelines are unduly restrictive or open to misinterpretation, the physicians will likely provide futile CPR. Since the administration of futile medical treatment is tantamount to inflicting cruel and unusual punishment, a physician has a moral, ethical, and legal duty to prohibit such treatment.<sup>169</sup> Clear guidelines that recognize a patient's limited right to receive treatment combined with a working definition of futility can dissuade a physician's use of slow codes. If the physician does not have to resort to covert issuance of DNR orders, he can maintain an open channel of communication to the patient.

In order for all of these steps or suggestions to be codified and implemented successfully as constructs for decision-making there must be a level of educated communication opened between patient and physician. A will to understand the reality of death is, sadly, all too often clouded by emotions and not guided by rational thinking. It is here where, ultimately, a physician must – consistent with these suggested guidelines – exercise his informed professional judgment and act in the best interest of his patient thereby assuring not only a humane outcome but one that does not impose an undue economic burden on the patient, his family, and society.

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<sup>167</sup> See generally Smith, *supra* note 5, for a recommendation of a definition of futility.

<sup>168</sup> See *id.* at 36 (discussing societal benefits obtainable by defining medical futility).

<sup>169</sup> See *id.* at 32-34.

